Small Business Health Options Program (SHOP)

Insurance Application for Employees

Use this application to give us more information about you and the dependents that you may want to cover through the health coverage offered by your employer.

THINGS TO KNOW

Apply faster online	To avoid delays with your application, apply online at **www.kynect.ky.gov** or follow the link sent to you by your employer.
Compare plans online	Visit www.kynect.ky.gov to compare plan options and prices to help you choose a health plan that meets your needs.
To get help	• **Contact your employer:** Ask your employer first about any questions you may have. • **Online**: **www.kynect.ky.gov** • **By phone:** Call Customer Service at **1-855-4kynect (459-6328)** • **En Español:** Llame a nuestro Servicio al Cliente gratis al **1-855-4kynect (459-6328)** • **TTY** users call **1-855-326-4654**
What happens next?	• Mail or fax your completed, signed application to: **Office of the Kentucky Health Benefit Exchange** **P.O. Box 4090** **Frankfort, KY 40604** **Fax: 1-502-573-2005** • You will hear back from us when we receive your application. • We will send you detailed information about the steps you will need to take to enroll in a plan offered by your employer. You will need to go online, call us, or get assistance from an insurance agent or kynector to enroll in a plan.
Other Options	If your share of the cost of employee-only coverage is more than 9.5% of your household income, you may be able to get help paying for insurance as an individual (not as an employee) through kynect. Visit **www.kynect.ky.gov** to learn more.

Your information is private.

- We'll keep your information private as required by law.
- We'll use the information on this form only to collect additional information about you or any dependents you may want to cover through your employer-sponsored health insurance plan.

kynect
Kentucky's Healthcare Connection

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If someone else is helping you fill out this application, use Appendix B to give us that person's information.

Who is your employer?	Company Name

Get started with your application below.

STEP 1 Information about You, the Employee

1. First name, Middle initial, Last name & Suffix			2. Social Security Number
3. Date of Birth (mm/dd/yyyy)	4. Gender ☐ Male ☐ Female	5. Used tobacco at least 4 times a week in the past 6 months? ☐Yes ☐No	
6. Home Address - ☐ **Check here if you do not have a Home Address. You will still have to enter a Mailing Address below.**			
7. City	8. State	9. Zip Code	10. County
11. Mailing Address **(Only required if different from Home Address)**			
12. City	13. State	14. Zip Code	15. County
16. Email Address			
17. Primary Phone Number ☐Home ☐Work ☐Cell ( )		18. Secondary Phone Number ☐Home ☐Work ☐Cell ( )	
19. ☐ Check here to allow kynect to send text message alerts to your primary phone number.		20. ☐ Check here to allow kynect to send text message alerts to your secondary phone number.	
21. Preferred Language Spoken (if not English)		22. Preferred Written Language (if not English)	
23. Are you of Hispanic, Latino or Spanish origin? (**OPTIONAL**) ☐Yes ☐ No			

24. Race - (**OPTIONAL**)

☐ White	☐American Indian	☐Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐Alaska Native	☐Japanese	☐ Other Asian	☐ Samoan
☐ Chinese	☐Asian Indian	☐Korean	☐ Native Hawaiian	☐ Other Pacific Islander

- Do you want coverage for yourself only? **Skip to Step 3.**
- Do you want coverage for your dependents? **Go to Step 2 to enter your dependents' information.**
- Do you **not** want to enroll in the coverage offered by this employer? **Skip to Step 4.**

If you need help with your application, contact your employer, an insurance agent or a kynector. You can also apply faster online at **www.kynect.ky.gov** or by calling **1-855-4kynect (459-6328)**. Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).

STEP 2 Information about your Dependents

Provide details for each dependent who is applying for coverage. Use additional pages if needed.

Dependent 1

1. First name, Middle initial, Last name & Suffix

2. Social Security Number		3. Relationship to you
4. Date of Birth (mm/dd/yyyy)	5. Gender ☐ Male ☐ Female	6. Used tobacco at least 4 times a week in the past 6 months? ☐Yes ☐No

7. Is this person of Hispanic, Latino or Spanish origin? (**OPTIONAL**) ☐Yes ☐ No

8. Race - (**OPTIONAL**)

☐ White ☐ American Indian ☐ Filipino ☐ Vietnamese ☐ Guamanian or Chamorro
☐ Black or African American ☐ Alaska Native ☐ Japanese ☐ Other Asian ☐ Samoan
☐ Asian Indian ☐ Korean ☐ Native Hawaiian ☐ Other Pacific Islander
☐ Chinese

9. Does DEPENDENT 1 live at the same address as you?
☐Yes. **If yes,** do not enter an address below. ☐No. **If no**, enter DEPENDENT 1's address below.

10. Home Address	11. Mailing Address **(Required if different from home address)**

Dependent 2

1. First name, Middle initial, Last name & Suffix

2. Social Security Number		3. Relationship to you
4. Date of Birth (mm/dd/yyyy)	5. Gender ☐ Male ☐ Female	6. Used tobacco at least 4 times a week in the past 6 months? ☐Yes ☐No

7. Is this person of Hispanic, Latino or Spanish origin? (**OPTIONAL**) ☐Yes ☐ No

8. Race - (**OPTIONAL**)

☐ White ☐ American Indian ☐ Filipino ☐ Vietnamese ☐ Guamanian or Chamorro
☐ Black or African American ☐ Alaska Native ☐ Japanese ☐ Other Asian ☐ Samoan
☐ Asian Indian ☐ Korean ☐ Native Hawaiian ☐ Other Pacific Islander
☐ Chinese

9. Does DEPENDENT 2 live at the same address as you?
☐Yes. **If yes,** do not enter an address below. ☐No. **If no**, enter DEPENDENT 2's address below.

10. Home Address	11. Mailing Address **(Required if different from home address)**

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Dependent 3

1. First name, Middle initial, Last name & Suffix

2. Social Security Number		3. Relationship to you
4. Date of Birth (mm/dd/yyyy)	5. Gender ☐ Male ☐ Female	6. Used tobacco at least 4 times a week in the past 6 months? ☐Yes ☐No

7. Is this person of Hispanic, Latino or Spanish origin? (**OPTIONAL**) ☐Yes ☐ No

8. Race - (**OPTIONAL**)

☐ White	☐ American Indian	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Alaska Native	☐ Japanese	☐ Other Asian	☐ Samoan
☐ Chinese	☐ Asian Indian	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander

9. Does DEPENDENT 3 live at the same address as you?
☐Yes. **If yes,** do not enter an address below. ☐No. **If no**, enter DEPENDENT 3's address below.

10. Home Address	11. Mailing Address **(Required if different from home address)**

STEP 3 Additional Questions

1. Is anyone on this application **American Indian or Alaska Native**?

☐**YES.** **If yes,** answer questions a and b. ☐**NO.** **If no,** go to question 2.

a. Who? _____
b. Is this person a member of a federally recognized tribe, band, nation, community or other group?
☐Yes. If yes, answer questions c-e. ☐No. If no, go to question 2.
c. What tribe? _____
d. What state is this tribe primarily located in? _____
e. Is this person eligible to receive Indian Health Services? ☐ Yes ☐ No

2. Does anyone on this application have **other health coverage** now, including dental and major medical coverage that is not Medicaid or KCHIP?

☐**YES.** If **yes**, answer the question below. ☐**NO**

Name of insurance company: _____

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STEP 4 Do not want employer-sponsored coverage

☐ **I am waiving my employer-sponsored coverage.**

What is the reason for waiving the health coverage offered by this employer?

☐ I have individual private insurance
☐ I have insurance from another job
☐ I have insurance through my spouse/partner
☐ I have insurance through a parent
☐ I have Medicare
☐ I have Medicaid or CHIP
☐ I have TRICARE
☐ I have VA coverage
☐ I don't live in health plan service area
☐ I don't wish to participate
☐ I have an exemption

STEP 5 Sign and Date this Application

- I am signing this application under penalty of perjury which means I have given true answers to all the questions on this form to the best of my knowledge and belief. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.
- I know that I must tell kynect if anything changes from what I wrote on this application within 30 days of the change. I can visit **kynect.ky.gov** or call **1-855-4kynect (459-6328)** to report any changes.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Voter Registration: If I am not registered to vote or not registered where I currently live, I can choose to register to vote by checking yes below. If I check yes, I will receive a voter registration application in the mail. Checking yes or no below does not affect how much payment assistance I can get.
☐ **Yes**, I want to apply to register to vote. An application will be mailed to me. ☐**No**, I don't want to register to vote.

- **My right to appeal.** If I think kynect has made a mistake, I can appeal its decision. To appeal means to tell someone at kynect that I think the action is wrong, and ask for a fair review of the action.

Signature	Date (mm/dd/yyyy)

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